3.061 Bed Bank Reductions and Resumption
The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.

3.062 Bed Bank Restrictions

a. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.

b. The total beds for rate setting and banked beds cannot exceed the total licensed beds.

c. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.

If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.

d. If banked beds are part of a phase down, the beds will be expunged from the bed bank.

3.070 Exclusions
If the facility has a total of 50 or less beds for rate setting (Section 3.040), including any distinct part ICF-MR or distinct part IMD units in the total facility, they are excluded from the patient days at minimum occupancy provision (Section 3.01 0).

3.100 DIRECT CARE ALLOWANCE

3.110 Types of Payment Rates
The payment allowance for direct care will be computed for each facility so as to establish a rate for each of the following levels of care:

(a) A skilled care rate (SNF).
(b) An intense skilled nursing (ISN) rate.
(c) An intermediate care rate (ICF 1).
(d) A limited care rate (ICF 2).
(e) A combined personal care rate (ICF 3) and residential care rate (ICF 4).
(f) A developmentally disabled 1A rate (DD 1A).
(g) A developmentally disabled 1B rate (DD 1B).
(h) A developmentally disabled 2 rate (DD 2).
(i) A developmentally disabled 3 rate (DD 3).

3.115 Patient Days
Adjusted patient days from the base cost reporting period (Section 3.020) shall be used in the calculation of the direct care allowance. Any patient days classified in a level of care greater than the facility is licensed to provide shall be reclassified downward to the highest level of care for which the facility is licensed. All Medicare adjusted patient days shall be classified as intensive skilled nursing days (ISN).

3.118 ICF-MR Facilities
A facility which has a distinct part certified as ICF-MR shall submit a combined cost report under Section 1.176. Payment rates shall be determined in a combined rate calculation which includes the ICF-MR distinct part and those NF distinct parts which are covered by the combined cost report. This combined calculation of rates shall apply even if each distinct part has a separate provider identification number.

3.120 Method of Computation of Direct Care Allowance

3.121 Inflation Adjusted Expense
The facility's actual allowable direct care expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated/ deflated from the cost reporting period to the common period using the inflation factors in Section 5.310. Dividing the sum of these inflated expenses by adjusted patient days yields per day inflated expenses.

3.126 Facility Direct Care Maximum
The facility's Case Mix Index is the average of the case mix values in Section 5.420 weighted by the adjusted patient days for each level.. Thus,

Case Mix Index = Σ(Adjusted Patient Days by Level of Care * Case Mix Weights) / Total Adjusted Patient Days

The facility's Direct Care Maximum is the product of its Case Mix Index times the Statewide Direct Care Maximum in Section 5.430 times the "New" Labor Factor in Section 5.410. Hence,

Direct Care Maximum = Case Mix Index * Statewide Direct Care Maximum * Labor Factor

3.126(a) Adjustment to Case Mix Index
Facilities that have beds for rate setting (Section 3.040) of fifty beds or less and are certified only as a nursing facility will have a twenty percent (20%) increase in their case mix index. Facilities that are certified as ICF-MR facilities either in whole or in part are not eligible to have its case mix index adjusted under this section.

3.127 Direct Care Base Allowance
The facility's Direct Care Base Allowance is the lesser of the facility's actual allowable expense per patient day times the minimum occupancy factor in Section 3.030 or the maximum in Section 3.126 times the minimum occupancy factor in Section 3.030.

3.128 Direct Care Reimbursement Period Allowance
The facility's Average Reimbursement Period Allowance will be its Base Allowance plus an Inflation Increment. The inflation increment is the facility's Case Mix Index times the Statewide Inflation Increment in Section 5.440. Thus,

Average Reimbursement Period Allowance = Base Allowance + Inflation Increment

Where

Inflation Increment = Case Mix Index * Statewide Inflation Increment

The Reimbursement Period Allowance shall be allocated proportionately by Level of Care. This allocation is done by dividing the Reimbursement Period Allowance by the facility's Case Mix Index and multiplying the result by the Case Mix Weights in Section 5.420.

3.129 Alternate Direct Care Reimbursement Period Allowance
The Alternate Direct Care Allowance will be calculated as set forth in Sections 3.126, 3.127 and 3.128 except that the "Old" Labor Factor in Section 5.410 will be used in calculating the facility's Direct Care Maximum and no Inflation Increment will be added to the Base Allowance. The facility will receive the greater of the Direct Care Reimbursement Period Allowance under Section 3.128 or the Alternate Direct Care Reimbursement Period Allowance.

3.200 SUPPORT SERVICES ALLOWANCE

3.220 Method of Calculation
Allowable expenses associated with a facility's provision of dietary and environmental services shall be combined, and payment determined, according to the following modified cost formula:

P = Dietary and Environmental services payment allowance

E = Facility's actual allowable expenses for dietary and environmental services (per patient day) adjusted by a composite inflation/deflation factor applied to the common period. The inflation factors are listed in Section 5.320.

Emin = Expense at minimum occupancy, E * Minimum Occupancy Factor in 3.030

T1 = Target 1 as described in Section 5.510

T2 = Target 2 as described in Section 5.510

I = Per patient day increment under 5.510

If Emin is less than T1,
P = E + I + (0.04 * (T1 - E))

If Emin is equal to or greater than T1, but equal to or less than T2,
P = T2

If Emin is greater than T2,
P = T2 + (0.05 * T2/E) * (E - T2))

3.250 Administrative and General Services Allowances

3.251 Method of Calculation

Payment for allowable expenses associated with the facility's provision of Administrative and General services shall be determined according to the following formula:

P = Administrative services payment allowance
E = Facility's actual allowable expenses for administrative and general services (per patient day) adjusted by an inflation/deflation factor applied to the common period. Inflation factors are listed in Section 5.330.
Emin = Expense at minimum occupancy, E * Minimum Occupancy Factor in 3.030
M = Per patient day maximum under Section 5.551.
I = Per patient day increment under 5.551

If Emin is less than maximum,
P = E + I

If Emin is equal to or greater than maximum,
P = M + I

3.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

3.310 Method of Computation

Fuel and other utility expense shall be determined as described below. Payment shall be determined by the following modified cost formula:

Payment = Fuel and utility payment allowance
Expense = Facility's actual allowable expenses per patient per day for fuel and utilities as adjusted by component inflation/deflation factors to the common period. Inflation factors are listed in Section 5.340.
Emin = Expense at minimum occupancy, E * Minimum Occupancy Factor in 3.030
Target = Target expense for facility's location. See Section 5.610 for targets.
Inflator = Inflation factor to adjust payment and expense to the payment rate year. (See 5.612.)

If Emin is less than the target
Payment = [Emin X Inflator]

If Emin is equal to or greater than the target
Payment = [Target X Inflator]

3.340 On-Site Water and Sewer Plants
For facilities which have on-site water and sewer plants, costs associated with maintaining such operations will be included in the support services payment allowance, not the fuel and utilities payment allowance. For such facilities, the utility target will not be adjusted downward to reflect the absence of costs associated with the water and sewer functions, nor will the support services payment allowance be adjusted upward to reflect the presence of costs associated with the water and sewer functions.

3.360 Seasonal Cost Variations
If a facility's base cost report is not for a twelve-month period, the heating fuel and utility expense shall be adjusted for seasonal cost variations. Whenever possible, a twelve-month period for heating fuel and utility expense should be used with such expenses adjusted to the time period covered by the patient day count. If twelve months cannot be acquired, then heating fuel expenses should be adjusted to a twelve-month period based on heating degree days.

3.400 PROPERTY TAX ALLOWANCE

3.410 Tax-Paying Facilities
Allowable property tax expense shall be based on the tax due for payment by the provider (or the lessor of the building) in the calendar year in which the payment rate year begins times the minimum occupancy factor in Section 3.030. For example, a July 2000 payment rate will include the amount of the December 1999 property tax bill plus an increment described in Section 5.700. The increment in Section 5.700 is limited to 100% of the tax amount due per patient day. Alternative cost reporting may be allowed under provisions in Section 4.000.

3.420 Tax-Exempt Facilities
The property tax allowance for tax-exempt providers may include the cost of needed municipal services. For municipal service fees, the expense shall be the expense for municipal services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period times the minimum occupancy factor in Section 3.030. The operating expense will be inflated/deflated to the common period by the support services inflation factor. Alternative cost reporting may be allowed under provisions in Section 4.000. The payment rate will include the inflated amount plus an increment described in Section 5.700 . The increment in Section 5.700 is limited to 100% of the allowable municipal service fees due per patient day. For operating expenses incurred by the facility, the expense will be from the cost reporting period used for other payment allowances.

3.500 PROPERTY PAYMENT ALLOWANCE

3.510 General
The property payment allowance will be a per patient day amount based on: the equalized value of the nursing home; target amounts based on service factors established by the Department; and the nursing home's allowable property-related expenses. This allowance is intended to provide payment for ownership, and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets. The asset value of nursing homes acquired at nominal or no cost shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program. Depreciation life shall be at the greater of 20 years or balance of 35 years from date of construction. The minimum estimated useful life of used movable equipment will be 5 years. This life will be applied to the composite value of the acquired equipment.

3.520 Allowable Property-Related Expenses
Allowable property-related expenses include: depreciation, interest on plant asset loans, amortization of construction-related costs, amortization of bond discount and premium, lease and rental expenses, and property and mortgage insurance. These costs must be reported in accordance with generally accepted accounting principles (GAAP) and must be necessary for providing nursing home patient care.

The cost reports for the base cost reporting periods and alternative cost reporting periods, as defined in Sections 1.302 and 4.000, will be the source for the information used to determine allowable property-related expenses.

Allowable costs will be adjusted to reflect any limitation on the revaluation of capital assets or lease limitations required under Sections 3.522 or 3.523.

3.521 Maximum on Allowable Property-Related Expenses
Annual allowable property-related expenses will be limited to 15% of the equalized value of the facility.

3.522 Changes of Ownership

If a facility changes ownership on or after October 1, 1985, a change in valuation will be allowed the new owner of the facility. The new owner's valuation will be the lesser of the purchase price or maximum valuation. The maximum valuation is calculated by multiplying the sellers annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller of the facility.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowable value related to capital assets:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller, will be the base value;

2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership;

3. The lesser percentage of CPI or DPI described in the first paragraph of this Section 3.522 will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum;

4. This initial maximum will be compared to 108% of the equalized value described in Section 3.531 below and the lesser value allowed as the maximum allowable value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value from Section 3.531.

If more than one nursing home is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

This section does not apply to changes of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

3.522(a) Expenses Associated with Change of Ownership Limited by Section 3.522

If a facility's valuation is limited under Section 3.522 the associated depreciation, amortization, and interest expenses will also be limited. Reported depreciation, interest and amortization expenses will be multiplied by the ratio of the above maximum to the actual purchase price to determine allowable expense. If the valuation of assets of the new owner are not limited to the maximum in section 3.522 actual costs will be allowed subject to section 3.520 allowability.

3.523 Lease and Rental Expense

1. Lease Maximum determination for on-going leases. If a facility was leased prior to the current cost reporting period, the maximum allowable lease expense for the current cost report period, will be limited to the lower of the actual lease payments or the total of the allowable lease expenses from the previous years cost reporting period multiplied by one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumers (United States City average).

2. Lease Maximum determination for previously owned but never leased. If a facility is leased during the current cost reporting period but was not previously leased, the allowable maximum lease expense will be determined by reference to the current owners year(s) of acquisition of the facility's fixed assets to the current cost reporting period. The year(s) of acquisition is/are the year(s) the facility was purchased or constructed by the owner. The lease maximum will be determined by: a) If the facility is still owned by the original provider that constructed the facility- divide the original cost(s) of construction/acquisition adjusted by one-half of the Consumer Price Index, by the original costs(s) of construction/acquisition; or b) If the facility was previously purchased – divide the allowable purchase price adjusted by one-half of the Consumer Price Index plus capital additions, by the allowable purchase price plus capital additions from the cost report used for rate setting prior to the lease (per Section 3.522). This ratio will then be applied to the allowable property expenses, related to the assets now leased, and that were included in rates effective June 30, 2000 to determine the maximum allowable property expense subject to number 5 below and Section 3.523.(a). The lower of actual or calculated maximum lease expense shall be used for determining the property reimbursement under Section 3.530.

3. Lease Maximum determination for new or replacement facilities. For new or replacement facilities that began operation in the cost report used for 2000-2001 rate setting, the lease expense paid is the maximum allowable for 2000-2001 subject to all other cost standards and formula limitations.

4. Lease determination for a sale and lease back. For purposes of this section, an unrelated party sale and lease back transaction will be limited by the percentage increase that would be applied if the facility had been leased prior to the base cost reporting period. The lease maximum shall be determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses for the assets that are now leased from the year before the sale.

5. General provisions of allowable lease determinations. This limitation will only apply to lease expense and other capital costs as of the date of lease inception. It will not apply to depreciation, interest, lease and rental or other property costs on assets, whether the lessee or lessor acquired the assets after lease inception, such as the purchase or leasing of new equipment or leasehold improvements.

If a facility is unable to provide adequate support of the dates of asset acquisition, the procedure under Section 3.522 for imputing average years of ownership may be applied.
Lease expense includes the actual payments required under the lease contract. Lease expenses determined under the capitalized lease method of Financial Accounting Standards Board Statement No. 13 will not be recognized.

The costs of acquiring existing leasehold rights are not allowable.

3.523(a) For leases existing prior to the cost report used for 2000-2001 rates, the limit calculated under this section will be increased for depreciation and interest expenses incurred by a lessor for leasehold improvements completed on or after July 1, 2000. The amount of increase will be calculated as if the lessee had made the improvements. This increase will be allowed only after a written agreement by the lessor has been received by the Department guaranteeing access to all records relating to the claimed expenses.

3.524 New Facilities, Replacement Facilities and Significant Licensed Bed Increases or Decreases after July 1, 2000
For new facilities licensed after July 1, 2000, and facilities with significant licensed bed increases or decreases after that date (as defined in Sections 1.305 and 1.304 respectively), the property payment allowance will be recalculated using the cost reporting periods and procedures described in Sections 4.300, 4.400, or 4.500.

The property payment allowance will also be recalculated when a facility has replaced a significant number of licensed beds. ("Replacement" is defined in Section 1.306.) (A "significant" replacement is defined as the replacement of the lesser of: (1) 25% of licensed bed capacity or (2) 50 beds.) When a significant replacement has occurred, the property payment allowance will be based on at least a six-month cost reporting period which begins within five months after the first of the month following licensure of the replacement bed area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

3.525 Depreciation and Amortization

1. Amortized A& G expenses. Amortization of the costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, and letter of credit fees) are not considered property-related expenses but are allowable expenses under the administrative and general component. Financing fees include such items as, but not limited to, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees. Amortization of such fees is allowable in A & G. Write off of the entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.

2. Amortized property expenses. Amortization of bond discounts and premiums are to be considered an element of interest expense. Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing (bonds, mortgages, etc.) shall be allowed as property.

3. Depreciation expense. Depreciation expense must be calculated under a straight-line method over a useful life, consistent with generally accepted accounting principles (GAAP). Useful lives will be determined by reference to the useful lives guidelines published by the American Hospital Association.

3.525(a) Minimum Useful Life for Plant Assets
Depreciation for either the initial construction of buildings or building additions (including fixed equipment and land improvements) must be based on a minimum useful life of 35 years from the earlier of: 1) the date of initial licensure of the facility as a nursing home or other health care facility, or 2) the date of initial occupancy. Remodeling projects of existing licensed facilities will be depreciated according to American Hospital Association (AHA) guidelines for each of the individual components of the project. A minimum estimated useful life of 20 years will be applied to facilities purchased after July 1, 1988. New movable equipment will be depreciated according to AHA guidelines. The minimum estimated useful life for purchases of used movable equipment will be 5 years. This life will be applied to the composite value of the purchased equipment.

3.525(b) Expenses Directly Related to Establishing Units for Services to Ventilator Dependent Residents
A facility's additional expenses for depreciation and interest directly related to establishing a unit for ventilator dependent residents may be exempted from the limitations and maximums under Sections 3.500. "Directly related" means that the costs have been incurred solely as a result of creating this unit and the equipment acquired or remodeling performed benefits only this unit. Prior approval by the Department (i.e., Administrator of the Division of Health Care Financing) of the remodeling project or equipment acquisition is required. This adjustment is only available for projects completed after July 1, 1993.

3.526 Interest Expense
Generally, interest expense on loans for acquisition of nursing home plant assets and equipment is an allowable property-related expense. Interest expense must be reasonable and necessary to be considered allowable. "Necessary" means that the interest is incurred on a loan necessary to satisfy a financial need and for a purpose reasonably related to nursing home resident care. Allowable interest expense on debt incurred for the acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing home patient care is a property-related expense.

3.526(a) Basis for Allowable Interest Expense
Allowable interest expense is based on:

1. Proper accrual under Section 1.302;
2. Recognizable debt balances under Section 3.526(b);
3. A "systematic reduction of debt" under Section 3.526(c);
4. Financing terms that would be incurred by a "prudent buyer" at the time a debt is created; and
5. The net amount remaining after investment income is offset.

3.526(b) Recognizable Debt Balances
Interest expense will be allowed only on debts which:

First, are for the acquisition of the plant assets listed in Section 3.526 that are directly related to nursing home patient care;

Second, have been limited or allocated, if necessary, under Section 3.522; and

Third, do not exceed 110% of Equalized Value per Section 3.531(b).

3.526(c) Systematic Reduction of Debt
Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt. The calculation of this limitation varies based on whether a facility makes at least annual principal payments or deposits to a segregated interest-bearing account.

If a facility makes at least annual principal payments or deposits to a segregated, interest-bearing account which will result in repayment of the debt at maturity, a systematic reduction of debt means a debt which has:

1. Payments of interest and principal which are uniform over the total length of debt; and
2. A length not exceeding the lesser of forty (40) years or the remaining useful life of the longest lived asset acquired with debt proceeds.

Allowable interest expense is predicated upon required systematic reduction of debt.

If a facility does not make at least annual principal payments or deposits, a systematic reduction of debt will be determined by the Department through:

1. An amortization schedule for a period of thirty (30) years from the date of asset acquisition;
2. Applying the interest rate as stated in the debt contract;
3. For debt contracts entered into prior to July 1, 1990, assuming a principal reduction schedule beginning July 1, 1990, and ending thirty (30) years from the original loan date; and
4. Reducing the calculated interest expense by any investment income on segregated funds.

3.526(d) Interest Expense Related to Refinancing of Debt
The recognizable debt balance following refinancing will be determined as:

1. The remaining balance of the original debt as determined under Sections 3.526(b) and 3.526(c); plus
2. The cost of assets acquired in the year of refinancing and the following two fiscal years as part of a plan approved by the Department; plus
3. The financing fees related to the refinancing.

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

Systematic reduction of debt under Section 3.526 is required for refinancing arrangements.

3.526(e) Reduction for Investment Income
The allowable interest expense after applying Sections 1.270 and 3.526(a)1 through 4 will be reduced by the amount of any investment income of the facility or related entities, including foundations, home offices, etc. per Section 1.270, to the extent that total property related expenses exceed the Target (T1) described in Section 3.532. Investment income offset will not include income from donor-restricted funds provided that there is separate accounting for such funds, that the funds are used for their intended purpose, and there is no future benefit to the donor, grantor, or endower. Reserves needed by Continuing Care Retirement Centers to offset lifetime contracts can be calculated by their actuaries if lifetime contracts do not require residents to apply for Medicaid if the resident's fund are exhausted.

3.527 Property Insurance
Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and for non-nursing home areas. Allowable property insurance expense includes mortgage insurance required by the lender.

3.528 Inadequate Documentation
Where the provider, or in the case of changes of ownership, the buyer or seller of a nursing home, is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or if the provider does not comply with property documentation requests by the Department or the contractor under Section 3.531, the Department will determine the values, dates and data through use of secondary sources of information, such as income and property tax records, and may use the source which results in the lowest value or the lowest property payment allowance.

3.530 Calculation of Property Allowance

3.531 Equalized Value
The equalized value will be derived from the values determined by an independent contractor under contract with the Department, using the E. H. Boeckh Commercial Valuation System. Any values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the E. H. Boeckh valuation after adjustment under Sections 3.531(a) and (b). These values will not be modified by any sales price; by a market appraisal by a certified appraiser on behalf of the facility; or by the assessed value on the property tax rolls.

The total value of the facility will be the sum of the values determined for the separate sections of the facility.

A facility's equalized value shall be based upon the values determined above, including adjustments, unless the facility does not render payment under Section 4.697 within a reasonable time period. In such instance, the facility's property allowance will be reduced by applying fifty percent of the facility's June 30, 2000, DRC and Undepreciated Replacement Cost (URC) under Section 3.531(b) or by fifty percent of the facility's June 30, 2000, property allowance, whichever is lower. This reduction applies to both the interim rate granted, if any, and the final rate. Upon facility payment of the appraisal cost, this reduction will be restored on a retroactive basis to the effective date of the reduction, and the facility property allowance will be calculated as determined by the provisions of the Methods.

3.531(a) Allocation for Areas Not Related to Routine Services
The values derived from the Boeckh valuation will be adjusted to exclude the value of areas not related to routine services. To the extent possible, this adjustment will be based on the square footage used in the Boeckh valuation.

3.531(b) Maximum on Equalized Value
The Undepreciated Replacement Cost (URC) arrived at under the Boeckh valuation system shall not exceed the equalized value in Section 5.830 times the beds for rate setting (Section 3.040) for allowances calculated under this Methods. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This calculation can be expressed as follows:

For: Boeckh URC = The Boeckh Undepreciated Replacement Cost after Section 3.531(a) square footage adjustments;

Boeckh DRC = The Boeckh Depreciated Replacement Cost after Section 3.531(a) square footage adjustments

URC = Allowable Undepreciated Replacement Cost (the lesser of Boeckh URC or the equalized value in Section 5.830)

Then allowable Equalized Value (EV) is calculated as:

EV = (Boeckh DRC/Boeckh URC) X URC

3.532 Property Allowance Calculation
A target amount (T1) will be calculated for each facility by multiplying the equalized value from Section 3.531 by a service factor described in Section 5.820 (a).

When a facility's allowable property-related expenses are less than the target amount (T1), the property payment allowance will be allowable expense plus the incentive value in Section 5.850 times the amount by which expense is less than the target (T1). When the facility's allowable property-related expenses are equal to or greater than the target amount, the property payment allowance will be the target amount plus 100% of the amount by which allowable expense exceeds the target up to the factor in Section 5.820 (b), and the cost share value in Section 5.840 times the amount by which allowable expenses under Section 3.521 exceed the factor in Section 5.820 (b).

This calculation can be expressed:

For:	E	=	Allowable property-related expenses up to Section 3.521 maximum;
	T1	=	The service factor in Section 5.820 (a);
	T2	=	The service factor in Section 5.820 (b);
	PA	=	Total property payment allowance;
	I	=	Increment described in Section 5.810;
	C	=	Cost Share Value described in Section 5.840; and
	N	=	Incentive described in Section 5.850.

Then: Where E is less than T1:

$$PA = (E + N * (T1 - E)) + I$$

Where E is equal to or greater than T1 and E is less than T2:

$$PA = E + I$$

Where E is greater than T2:

$$PA = (T2 + C * (E-T2)) + I$$

Facilities which have completed a Ch. 150 Resource Allocation Program approved project involving construction or renovation of physical plant between July 1, 1996, and December 31, 1997, will have a cost share percentage as described in Section 5.840(b). Nursing facilities that have a licensed bed capacity of 50 beds or less, after adjustments in Section 3.000, will have a cost share as described in Section 5.840(b). Facilities that are certified as ICF/MR, either in whole or in part, will have a cost share as described in Section 5.840(a), unless they have completed a RAP-approved project as noted above.

3.534 Per Patient Day Property Payment Allowance
To calculate the per patient day property payment allowance, the property allowance (Section 3.532) is divided by the adjusted patient days in Section 1.307 times the minimum occupancy factor in Section 3.030. If needed, the expenses shall be adjusted to the length of time covered by the patient days.

For calculating the per patient day property payment allowance for newly-licensed facilities and facilities with significant licensed bed increases, the patient day provisions of Sections 4.320 and 4.420 will apply. For replacement facilities, the minimum occupancy standard in Section 3.030 will be applied.

3.537 Maximum Decrease
A facility's payable property allowance will not be reduced by more than $3.50 per patient day from the allowance in effect on June 30, 2000. An exception to this maximum decrease is made if the June 30, 2000, allowance is subject to adjustment after June 30, 2000, for the lapsing of the "start-up" occupancy provisions for newly-licensed or expanded facilities. In these cases, the $3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods in effect on June 30, 2000.

3.600 OVER-THE-COUNTER DRUGS ALLOWANCE
Reimbursement for certain over-the-counter (OTC) drugs ordered by a physician and provided to Wisconsin Medicaid residents shall be made as part of the facility's daily rate. The OTC allowance will be based on the facility's cost of OTC services for Wisconsin Medicaid residents from the base cost reporting period, as limited by the provisions under Section 2.600.

Payment for OTC drugs will be determined using the following formula:

For:	P	=	OTC allowance;
	E	=	Facility's allowable expense for Wisconsin Medicaid resident OTC drugs as adjusted to the common period by an inflation/deflation factor (Inflation factors are listed in Section 5.330);
	Emin	=	Expense at minimum occupancy, E * Minimum Occupancy Factor in 3.030
	I	=	Inflation rate to payment period by inflation factor listed in Section 5.910; and

APD = Adjusted Wisconsin Medicaid patient days .

P = (Emin x I)/APD

3.650 PROVIDER INCENTIVES

3.651 Exceptional Medicaid/Medicare Utilization Incentive
Payment for the EMMUI supplement will be determined using the following formula:

EMMUI = F x BA

where F = The facility's adjusted Medicaid patient days plus Medicare patient days divided by the facility's adjusted total patient days under Section 1.307. F must be greater than or equal to 70% in order to receive the EMMUI.

and BA = The base allowance in Section 5.920

3.652 Energy-Savings Incentive
If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility will receive an incentive equal to the lessor of 25% of the projected cost of the project, as approved by the Department, or 25% of the actual cost of the project per year for two years. The incentive payment will be effective July 1 following completion of the project. Allowable costs for the project will be subject to minimum occupancy factor under Section 3.030.

3.653 Private Room Incentive

a. Basic Private Room Incentive (BPRI)
A basic private room incentive will be determined using the following formula:

BPRI = PRP x BBA

where PRP = Rooms licensed for single occupancy divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 15% **AND** the F from Section 3.651 must be greater than or equal to 70% in order to receive the BPRI

and BBA = The basic base allowance in Section 5.930

b. Renovation Private Room Incentive (RPRI) and Replacement Private Room Incentive (RPPRI)
A renovation private room incentive and replacement private room incentive will be determined using the following formula:

RPRI or RPPRI = PRP x RBA

where PRP = Rooms licensed for single occupancy divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 90% **AND** the F from Section 3.651 must be greater than or equal to 70% in order to receive the RPRI or RPPRI.

and RBA = The renovation base allowance in Section 5.930

A facility may receive only one incentive.

3.700 FINAL RATE DETERMINATION

3.710 General
Sections 3.710 through 3.770 describe the process for determining a facility's final payment rate by level of care for direct care services, support services administrative and general, fuel and other utility expense, over-the-counter drug expenses and property taxes. This process shall be followed whenever any payment allowance under Sections 3.100, 3.200, 3.250, 3.300, 3.400 or 3.600 is adjusted or recalculated. Any average amount under this section shall be the average as weighted by the adjusted patient days by level of care which were used in calculating the direct care allowance under Section 3.100. The Department shall specify the patient day period.

3.720 Base Rate

3.721 Base Rate Described
A facility's base rates shall be the total rates effective for each level of care for services rendered on June 30, 1994, excluding the capital allowance, ancillary add-ons, special allowances for local government-operated facilities and rate adjustments made by the Nursing Home Appeals Board, but including reimbursement for over-the-counter drugs under Section 3.600. An average base rate shall be calculated under Section 3.710 for each facility.

3.722 Base Rate Modification
The base rates shall be modified according to the following:

1. Adjustments. Base rates shall include any audit adjustments or corrections subsequent to June 30, 1994, that are deemed effective for date-of-service June 30, 1994.
2. Certification or Licensure Change. Upon a change in certification or licensure level of the facility, the base rate for any added level of care, for which no base rate exists, shall be the base rate from the next lower level of care.
3. Newly-Licensed Beds. A newly-licensed facility which is in its start-up period as of June or July 1994 shall have zero base rates. A facility with significant licensed bed increases which is in its start-up period as of June or July 1994 shall have as its base rates those rates effective at the end of the month prior to the licensure of the new beds.

   Such base rates shall be limited for the current rate calculation to a maximum which shall be the facility's average base expense as determined in Section 3.731. If the average base rate is limited by the maximum, base rates for each level of care shall be calculated by multiplying the unlimited base rates for each level of care by a ratio of the maximum divided by the unlimited average base rate.
4. Temporary Bed Reductions. If the June 30, 1994, base rates were retrospectively adjusted for temporary bed reductions due to renovation projects, such rates shall be the base rates for application of this section until completion of the renovation period. After completion of the renovation period, the base rates shall be those rates effective for date of service June 30, 1994, prior to the retrospective rate adjustment for recognition of the temporary bed reduction.

3.730 Projected Expense
The projected expense shall be the sum of the average expense per patient per day, which was used in the calculation of each allowance in Sections 3.100 through 3.400 and 3.600, after being adjusted to the payment year as follows:

1. Direct care inflation adjusted expense from Section 3.120 shall be inflated by 3.4%.
2. Support services expense from Section 3.220 shall be inflated by 3.4%.
3. Administrative and general services expense from Section 3.250 shall be inflated by 3.4%.
4. Fuel and utility expense from Section 3.310 shall be inflated by 3.4%.
5. The property tax expense from Section 3.400 shall be inflated by 3.4%.
6. Over-the-counter drug allowance from Section 3.600 shall be inflated by 3.4%.

3.740 Current Methods Rate
A facility's current Methods rate for each level of care shall be the sum of the payment allowances resulting from Sections 3.100 through 3.400 and 3.600. A weighted average current Methods rate shall be calculated

3.760 Hold-Harmless Rate
The facility's average hold-harmless rates shall be the base rates under Section 3.720.

3.770 Selection of Payment Rate

3.772 Hold-Harmless Rate
The hold-harmless rates under 3.760 shall be the facility's payment rates if both of the following conditions are met:

1. The average current Methods rate under 3.740 is less than the average base rate under 3.720.
2. The average current Methods rate is less than the projected expense under 3.732.

3.773 Current Methods Rate
The current Methods rates under Section 3.740 shall be the facility's payment rates if Section 3.772 does not apply.